200002/0004

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AND PLAY	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		ECI O4400m				
NAME OF PROVIDER OR SUPPLIER		8, WING		05/06/2015		
	AWN FAMILY CARE	STREETA	DORESS, CITY, S E FAWN DRIV	STATE, ZIP CODE		
		ASHEVII	LLE, NC 2880	3		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TO DEFICIENCY		ON SHOULD BE CO	
C 000	Initial Comments		C 000			 -
	Report of Blennial (Strickland on 05/06	Construction Survey by Frank /2015:				
	Records Indicate the	Records Indicate that this facility was first		CONSTRUCTOR	SECTION	
	This facility is licensed for a capacity of six (2).			aut da	20126	
ambulatory residents (able to evacuate v physical or verbal assistance during an		S (able to evacuate without		10r 0:	EUE)	
	emergency). Based facility is required to	on this information, this		REGE	VED	
	regulations ", the ap " regulations for fami 1978 Edition of the N	ninimum, desired standards oplicable portions of the 2005 ily care homes " and the forth Carolina State Building G). Residential Care Facility				
	There were deficiend survey and a Plan of	eles cited at the time of this Correction is required.		-		
C 117 F	lave Current San. A	nd Fire Safety Approvals	C 117			
	SECTION .0300 - TH IDA NCAC 13G .030 CONSTRUCTION	2 DESIGN AND				
s	re and building safet	nave current sanifation and y inspection reports which the home and available for	-			
1.1	his Rule is not met a -Based on observation rovided current docu	as evidenced by: on, the facility has not mentation for review.		BESONE	8	-4-15
(F	indings on 05/05/201	5				-
b	he facility does not h	ave a current fire and ion reports on site for	-			
n of Healt	h Service Regulation					
FORM	RECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVES SIGNA	TURE DA	mic A. A.	000	DATE

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Division	of Health Service Re	egulation			FOR	APPROVED
I STATEME	NY OF DEPICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY (PLETED
		FCL011297	B. WING			
NAME OF	PROVIDER OR SUPPLIER					06/2015
WHITE	FAWN FAMILY CARE H		FAWN DRI	STATE, ZIP CODE		
		ASHEVII.	LE, NC 288	03		
(X4) IO PREFIX TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL COENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X6) COMPLETE DATE
C 174	Continued From pag	je 1	C 174			
C 174	Building Equipment	Maintained Safe, Operating	C 174			
	 (a) The building an mechanical, and plu care home shall be r operating condition. 	HE BUILDING 17 BUILDING SERVICE d all fire safety, electrical, mbing equipment in a family maintained in a safe and pply to new and existing				
	maintained the entry	ion, the facility has not and interior conditions of the deffect all residents and staff				
	basement has exces:	15 door and frame has to longer useable. Also, the sive debris stored that is old wood furniture and paper		TOBER	PAIRED	8-4-15
[]	maintained the servic	on, the facility has not e of the laundry equipment is may effect all residents ry operations.				
- 17	Findings on 05/06/20 The dryer is venting in the exterior as requ	to the crawl space and not	. E	RYERUEDTED EXTERIOR	TOTHE!	5-15
e	naintained the service exhaust hood in a safe	on, the facility has not e of the kitchen range/stove e manner. This will effect while preparing cooking on	-	OBE REPLACES)	2-4-15
	ith Service Regulation					
ATE FORM		ten	OK	IL21	If continuedo	n sheet 2 of 3

Division of Health Service Regulation

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(×	(X3) DATE SURVEY	
			A. BUILDIN	(G: 01		COMPLETED	
haus os i		FCL011297	B, WINS_			05/06/2015	
	PROVIDER OR SUPPLIER			Y, STATE, ZIP CODE			
WHITE F	AWN FAMILY CARE H		E FAWN DF LLE, NC 28				
(X4) ID	SUMMARY STAT	TEMBAT OF DEFICIENCIES	10	PROVIDER'S PLAN OF C	ODDEON'S.		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THOUSENCY	ON SHOULD BE E APPROPRIA	E COMPLETE OTE DATE	
C 174	Continued From pag	ge 2	C 174				
	Findings on 05/06/2 The kitchen range e excessive grease bu	xhaust hood filter has					
	maintained the facilit manner. This will eft when entry to the fac	tion, the facility has not ty entry ramp the in a safe fect all residents and staff clifty occurs because of a trip		TO BE REPAIRE	E.N	0.4.15	
	hazard.	,			-20	8-7-15	
. [Findings on 05/06/20 The left-hand side er rotten lumber at it's b not level.	ontry ramp has damage due to ease adjacent to grade that is					
C 127	Building Service Equ	ipment-Heat	C 127				
	.2214) 1. There must be an	Equipment (10 NCAC 42C approved central heating					
E	system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. Built-in electric heaters, if used, must be installed or protected so as to avoid hazards to residents.			CALLSYSTEMO	PERAT	TONAL	
r	and room furnishings	. Unvented fuel burning table electric heaters are		IN ROOM 1+B	EMOD	5-14-15	
1 1	This Rule is not met : -Based on observati naintained the call sy esidents in the event	on, the facility has not stem. This could effect all					
T	indings on 05/05/201 he call system was r a 3.	5 not operational for Rooms 1					
on of Healt E FORM	th Service Regulation			IKIL21		finuation sheet 3 of 3	